FINAL REPORT FOR

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CASE STUDY: UGANDA HEALTH COOPERATIVE

Submitted to

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Land O'Lakes, Inc.

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By Ted Weihe[1]

Executive Summary

In 1994, Land O'Lakes began working with the Ugandan dairy industry with a USAID grant. By 1998, 35 dairy cooperatives were registered and operating as functional agribusinesses. The result has been increased incomes and improved food security for farm families and for Uganda. Land O'Lakes recognized that, in Uganda, dairy farmers often fell sick, missed work or had to sell their dairy cows due to health care emergencies. These difficulties could be avoided with health care plans and timely or preventive health care treatment.

In 1997, Land O'Lakes invited HealthPartners to enter a subcontract to implement community-based prepaid health care schemes in Uganda. HealthPartners viewed this request as a unique opportunity to expand their services and years of lessons learned to save lives in Uganda as part of their corporate social responsibility.

Together, Land O'Lakes and HealthPartners formed the Uganda Health Cooperative (UHC), which began by working with dairy cooperatives. By 2000, UHC decided to expand beyond dairy cooperatives to offer economical prepaid health care plans and began enlisting members from other existing groups such as coffee and tea cooperatives, micro-finance groups, burial societies and secondary schools.

Encouraging early treatment of potentially serious diseases and introducing preventive health care has lowered the costs of health care for many members, reduced employee absenteeism, and increased savings and steady income for health providers. In cooperation with Oracle Corporation, a database was developed specifically for UHC to track patient health and help make decisions on preventive care initiatives. Additionally, this system addresses income and loss by UHC and its frequency and types of health services. The health plans were also offered as an open benefit for members of a larger cluster of health care organizations, though none of them had sufficient funds to set up plans at their locations.

Providers that are often primary care hospitals and linked to rural clinics benefit from prepaid health plans because they receive reliable and regular sources of income. Member groups may select their provider and can change hospitals or clinics if they are not satisfied with their care. As a result, improving patient services has become a priority for providers.

[1] Ted Weihe prepared this case study based on extensive UHC documentation, especially by HealthPartners project management staff, Scott Aebischer and Jennifer Wenborg, as well as the UHC manager, Rebecca Joy Batusa in Uganda. An evaluation of the program was conducted by Delius Asiimwe of Makerere University in November 2000.

The Uganda Health Cooperative team has been expanding membership throughout Uganda, and now includes Kampala, the capital city in south central Uganda; Gulu and Arua in northern Uganda[2]; and Bushenyi, Kabale, Ishaka and Comboni in southwestern Uganda and Mbale in eastern Uganda. Currently, there are 67 groups serving over 9,000 members.

UHC studies show that preventable diseases comprised a large number of provider visits and that improving members' health education can reduce their health care costs. UHC's public health nurse makes presentations to members on topics ranging from planning healthy land usage with latrine placement to how and when to wash hands. Women's groups have joined together to learn how to build water tanks to collect rainwater. This provides a relatively clean source of water and saves long trips to local rivers for collection. An initiative to provide ambulance-like transportation for plan members was introduced in one remote location. This service did not prove cost-effective because *matutu* drivers could collect higher fees by picking general passengers in a taxi-like service. Presentations are given on nutrition and hygiene for members.

Safe birthing kits including sterile supplies are provided for expectant mothers in health plans. Malaria is the number one reason for medical treatment in Uganda. UHC has partnered with Commercial Market Strategies to provide insecticide-treated bed nets to reduce the incidence of malaria among plan members.

As the plans grew in numbers to nearly 60 and coverage of about 5,600 members, it had to be scaled back in 2004 because of funding cutbacks and reductions in UHC staff, who are necessary to promote and collect premiums. The cutbacks also reduced the number of smaller plans that were losing money. At 17 plans with about 3,000 members – mostly older and larger plans – the program is largely self-sufficient, with only about $3,000 in monthly staff salaries. The challenge is to take this experience and develop a strategy to achieve scale and sustainability.

I. Description of HealthPartners

HealthPartners began in the 1950s as a cooperative-based, consumer-governed organization. HealthPartners is now a family of nonprofit Minnesota health care organizations focused on improving the health of its members, its patients and the community. HealthPartners, and its related organizations, provide health care services, insurance and health plan coverage to nearly 660,000 members. Today, HealthPartners is comprised of more than 50 primary care, specialty care and dental clinics and regional medical centers. More than 9,600 employees staff the various HealthPartners organizations. To provide even greater access to health care services and facilities across the state, HealthPartners has developed long-term contractual relationships with approximately 70 medical groups at more than 700 sites totaling over 7,000 health care providers. HealthPartners is an organization that is committed to pursuing perfection.

[2] Due to security reasons, UHC is no longer in northern Uganda.

In 2002, HealthPartners Medical Group & Clinics received a grant totaling almost $2 million to participate in an important national initiative called "Pursuing Perfection: Raising the Bar for Health Care Performance." The Robert Wood Johnson Foundation and the Institute sponsor the initiative for health care improvement. HealthPartners has a number of other assets that make them an exceptional health care organization. HealthPartners Research Foundation supports and promotes research throughout the HealthPartners family of nonprofit health care organizations. HealthPartners Institute for Medical Education is among Minnesota's four largest providers of medical education, training more than 500 resident physicians each year. Founded in 1996, the Institute oversees residency programs at HealthPartner's Regions Hospital and continuing medical education programs for physicians, nurses and other medical personnel. HealthPartners viewed the partnership in Uganda as an extension of their local mission: to improve the health of its members, patients and the community.

II. Ugandan Heath Status

Uganda's population is about 24.7 million people with a geographic area of 91,134 square miles. Life expectancy is 45 years. The ratio of physicians to patients is 1:25,000. The infant mortality rate is 88 deaths/1,000 live births. The total fertility rate is 6.8 children born per woman. In 1996, 15 percent of Ugandan children died before age 5. The HIV/AIDS prevalence rate is 5 percent; at the end of 2001 there were 884,000 AIDS orphans. The leading causes of death are malaria, AIDS, diarrheal diseases, pneumonia and anemia.

The country's annual per capita health care expenses cost $12. Uganda's economy is primarily based on agriculture, which employs over 80 percent of the work force. Its Gross Domestic Product composition by sector is as follows: agriculture, 44 percent; industry, 17 percent; and services, 39 percent. The per capita income is $300. Total health care spending in Uganda averages less than $15 per person per year. Often when illnesses arise, Ugandans are forced to sell their livestock or land in order to come up with the cash to pay for their medical expenses; therefore, many will not seek treatment until they are on their deathbed. A cost analysis of a healthier population shows benefits, including fewer sick days for workers and students, increased production, increased retention rate of employees, decreased number of people dying from preventable and curable diseases, and many more.

When HealthPartners arrived in Uganda, the state of the health care system was poor. Ninety-nine percent of Ugandans had no health insurance of any kind. When care was delivered, people had to pay directly in cash for that care. A serious illness could quickly destroy the finances of a family, often forcing the sale of irreplaceable land or the family's milk-producing goats or cows to pay the doctor or hospital bill. All Ugandans can theoretically receive care directly from free government institutions, but the government itself admits that it does not have enough hospitals and clinics to provide care for most citizens.

The big picture still looks roughly the same, but UHC's grassroots efforts are beginning to spread through the country. The health care system in Uganda is primarily private/NGO-affiliated. Some government-supported care is offered. The cost of delivering care is often too high for the average citizen. Health care coverage, including preventive care, in rural areas is scarce or non-existent.

III. Rationale for Pre-Paid Health Care System

UHC partners with existing groups and creates a separate primary health care cooperative in order to tap a working infrastructure for health care and a sustainable ability for enlisting prepayment plans from their members. Each cooperative decides which health services to offer, establishes effective financial channels for premium payment, provides health education to co-op members and their communities, increases public awareness of the costs and benefits of prepaid plans, and uses local providers and pays them a predetermined fee.

Member benefits include:

- More predictable health care expenditures, with greater financial security in case of illness.
- Guaranteed access to a specified range of health services, with continuity of care.
- Reductions in seasonal exclusions, existing double payment practices and total health care payments.

In addition, a recent survey shows that households that make quarterly contributions to prepaid health care pay less than the average amount they would incur on heath care per quarter. Before the insurance program began, 43 percent of the patients who later enrolled and 48 percent of the patients in the comparison group were forced to sell an asset or borrow money. In the follow-up survey, only 16 percent of the insureds who obtained care in the previous month reported borrowing or selling assets, while 48 percent in the uninsured comparison group had done so.[3]

Provider benefits include:

- Increased revenue with reduction in losses due to patient's failure to settle hospital bills and cost of treatment due to members' use of preventive health care (and not waiting until very sick before going to hospital).
- More predictable revenue flow and less bad debt.
- More efficient provision of medical services to the community.
- Retention of clientele and continuity of care.

Community benefits include:

- Increased utilization of services and access to health education.
- Increased access to clean water, health care (new clinics).

[3] Commercial Market Strategies in Sub-Saharan Africa: Lessons Learned in Community Health Financing, Frank Feeley, Clinical Associate Professor, Boston University School of Health, September 2003.

- Better overall community health.
- Increased confidence in service providers.

The challenges for a pre-paid health plan include appropriate actuarial rates, coverage of administrative and transactional costs, staff training and marketing, cash flow challenges, provision of care delivery, and financial sustainability. In Uganda, the health care system is inadequate and present only in major cities (near total lack of rural access). The cooperative approach is designed to fit this economic reality by leveraging pools of local people so that they have better access to health care.

The key challenges are a lack of cash, little savings for sickness, and a poor history of the few commercial insurance schemes in which customers have been betrayed and bilked. As a result, distrust for insurers is ingrained and widespread, which can only be overcome with strong and credible local leaders who can persuade people to join the health cooperative in the face of their prior experiences.

Counterbalancing those problems is an immense, compelling and totally understandable desire by many Ugandans to provide affordable health care to their children, families and community. Ugandan caregivers, hospitals and physicians desire to make care more accessible and affordable.

IV. Project Methodology

The model of care delivery and financing designed and implemented by local staff is based on a belief in consumer-governed, cooperative health care. Each Ugandan health care co-op is self-governing; they select their own benefit plan and care provider, and set their own rules for enrollment and underwriting. Groups must be cohesive and accustomed to paying in installments or in advance for services, groups such as dairy, coffee and tea cooperatives, burial groups, schools, churches, micro-credit groups and, in some cases, entire villages.

UHC staff meets with cooperative leaders, members and families to explain the program's benefits, its finances, and local care system and conducts a survey to ascertain the level of support and participation. After a group selection process, each local co-op owns their health plan and does not require them to register their health schemes as an independent legal entity. UHC works with local authorities and providers, though in some cases, the health co-op has built its own clinic. In most cases, the co-ops simply serve as purchasing groups and buy coverage from local contracted caregivers. (Refer to Annex D.)

A health plan committee is elected and helps define the specific health care services desired by the group, encourages enrollment, collects premiums, and generally serves as the glue that holds each cooperative together.[4] Their duties include:

[4] When asked to describe their role, local co-op leaders often used the term "link." For instance, "I am the link between the national co-op people and our local members and the doctor. When our members have problems with the doctor, they come to me and ask me to speak for them."

- Managing the prepayment between the group and the provider, assuring that payment is being used for the health care needs of the members.
- Supporting member training and education, enrollment and marketing.
- Reviewing benefits and coverage.
- Providing liaison between members and providers.
- Managing and providing a forum for group exchange and training of other coops.

The commitment, energy, integrity and leadership of the health plan committees are critical to project success.

Once the group is established, UHC explains the program to local health providers that are able to provide the services, willing to accept prepayments, maintain the administrative system, and work with the communities on prevention measures. In the optimal set-up, the local provider has at least one full-time doctor and a staffed hospital with electricity, running water, and food available for patients.

UHC works with group leaders to develop the package of care, determine premiums, help set up collection systems including opening a bank account, and prepare the contract with the provider.

While the co-op collects the premium, it is provided directly to the provider, who accepts the risk that premiums will cover care costs. Contracts also include procedures for verifying current enrollment status (member ID cards), allowable benefits and benefit exclusions, payment schedules, and dispute resolution methods.

Membership ID cards are essential for protecting providers against fraud. ID cards are issued to each family (not per individual as it is in the U.S.) that list the names of household members. Co-payments are also printed on the member ID card so that the whole billing/adjudication/communication process is bypassed. When members seek care at the provider, they are expected to bring their ID cards and the latest receipt of premium payment. All household members who are listed on the card and included in the photograph will be eligible for treatment. New babies will also be covered until the card is renewed. Cooperative ID cards were designed to reduce health plan membership abuse by nonmembers.

Once doctors agree to participate, a benefits list and a price for the care are negotiated between the provider and the co-op. It is very important that the co-op set up the rules for this, but general guidelines and options need to be discussed with each group. Underwriting is a way to avoid enrolling only sick members and to spread risk. This is achieved through requiring that at least 60 percent of the group signs up, defining families, given the widespread polygamy (usually includes wife and blood children[5]), and increasing premiums for families larger than four. Underwriting also sets a specified time before coverage goes into effect, often delays maternity benefits for a year and

[5] A household is often defined as all the people who eat from the same pot.

places restrictions on any members who have certain pre-existing conditions (e.g., HIV/AIDS[6]) or are currently hospitalized.

Also, to address anti-selection, open enrollment periods are set each year and employers are encouraged to subsidize premiums. The purpose is to discourage employees to wait until they are sick to sign up. The most popular approach is to allow families to enroll at the time the group's premiums are due, which is normally on a quarterly basis. Benefit exclusions may include air ambulances, cosmetic surgery and out-of-area care.

Cooperative leaders know that the benefit package they design will result in costs that directly increase the premium their members have to pay. So the co-ops are very clear about the need for exclusions in benefit packages.

The list of benefits often selected by co-ops include general consultations, diagnosis and outpatient treatment, prenatal care, lab investigations, approved X-rays and ultrasound (when available at provider), prescribed drugs as per current formulary, STD treatment, dermatology and preventive care. Dental coverage varies widely among groups, depending on income and resources for care. Items usually not covered include family planning, self-inflicted injuries, AIDS and chronic disease, referral to other providers, cosmetic care, and transportation. None of the groups opted for chronic disease coverage.

Each co-op has co-payment requirements as a means to keep premiums down, discourage over-use of services, and provide immediate cash to providers. Currently, UHC co-op members are covered only for the care delivered at the local hospital or clinic.

Maternity coverage is covered by all co-ops but varies, with some that provide full services but may require mothers to have prenatal care prior to receiving maternity benefits. Other groups view maternity as a non-insurable event and provide only for catastrophic coverage such as C-sections.

Premiums are the most challenging component of the plans and tend to vary between 10,000 and 20,000 USh. for a family of four for three months (roughly $2 per month per family or $0.50 per person).[7] They are collected through an employer or by the group, usually on a quarterly basis. However, they can be collected annually if the cooperative members are paid at harvest time. The premium goes directly to the provider to keep the system simple, and names are placed in the database. Prepayment is an advantage because over 20 percent of medical costs are not recoverable as bad debt. It represents a flow of cash that augments donations often provided by donors.

Health care costs in Uganda are approximately $15 dollars per person per year, with about half from government and donors, the rest from patients. Ten percent of the

[6] To date, the plans cover symptomatic treatment in local settings for AIDS. But that could change, particularly in large cities where free government treatment programs for AIDS may be more robust and accessible.

[7] Given polygamy, a family under the plan is defined as "people who sleep under the same roof and eat from the same pot."

premiums go to sustain UHC for administrative costs for claims, ID cards, membership records, collections, negotiations with care providers, sales campaigns, computers, salaries, etc. Marketing strategies include talks to employer groups, health fairs, open houses, radio, drama shows and school lectures.

HealthPartners teamed up with Oracle Corporation to develop a database tracking system for Uganda. Several unique constraints had to be taken into consideration:

- Few health care records exist.
- Often the only health care tracking is a blue book containing a personal health history that may be carried or kept at home.
- Birth dates are often not tracked in Uganda.
- Knowledge of information technology is very limited and users are hard to find.
- Unreliable electric services often result in power surges or low voltage power, which can lead to loss of data and frequent system crashes.
- Generators and system grounding to provide consistent power are expensive.

The current Oracle system is basic but comprehensive enough to provide the needed reports. It includes a database on cooperative members, member services, diagnoses, premiums and expenses, and vaccinations. The system maintains current records, indicates patterns of usage, diagnosis and trend reports, patient histories, and income and losses. Software is constantly being updated and is expensive

V. Disease Prevention

One of the major areas of focus for a health care plan is prevention. According to the 1995 Burden of Disease study in Uganda, 4.75 percent of lives lost to premature death are due to ten preventable diseases. These diseases are responsible for the largest proportion of morbidity and mortality in Uganda, accounting for over 60 percent of the total burden of ill health. The ten diseases are malaria, acute respiratory tract infections, HIV/AIDS, tuberculosis, diarrhea diseases, malnutrition/under-nutrition, anemia, intestinal infestations, pregnancy and childbirth-related problems, and skin diseases.

UHC's goal is to improve the health of the community with preventive care as a priority to lower health costs and loss of income by members. Four key strategies include, as follows: (1) identification of preventable diseases within the community and expansion of existing projects, (2) better nutrition especially for children under five, pregnant and nursing women and elderly, (3) health education, and (4) prevention services including immunizations.

By regularly providing prevention initiatives, members feel they are receiving benefit for their premiums even if they are healthy. The UHC nurse carries out prevention lectures on the importance of hygiene and household safety (e.g., washing hands, separate toilets),

safer drinking water, safe birthing kits and insecticide-treated bed nets[8] to ward off mosquitoes.

Ugandan children often go away to boarding schools once they have completed primary school. Most secondary students do not attend a secondary school that is close to home. This means their family's health insurance will not cover them while at school.

But poor nutrition, infectious diseases, malaria and sexually transmitted diseases are just as prominent among school-age children as they are among infants and adults. They have a significant impact on the students, affecting their ability to attend class, study and retain what they learn. UHC developed School Health Made Easy Schemes (SHEMES) to address health care issues in the school population, including routine medical care and disease prevention.

HealthPartners also assisted in the creation of the Uganda Community Based Health Financing Association (UCBHFA) to share ideas and help other health care financing projects grow. UCBFHA is a voluntary association of 12 prepayment schemes with 24,000 collective members. UCBHFA meets quarterly to discuss common experiences and to benefit from shared technical expertise. The Uganda Ministry of Health plays an active role in UCBFHA.

VI. Lessons Learned

Focus marketing on entire communities or very large groups. Organized groups are able to understand and accept pre-paid plans, already have local leadership, and the health plan can piggyback on other group organizations and cohesive villages. Given staff limitations, local leaders must be available to promote and maintain the local health cooperative, including collection of premiums and links between the group and the health provider. Drama shows are a good vehicle in Uganda for marketing health plans to new groups and for raising awareness about preventive health care. Over-utilization of services can be expected from initial plans but diminishes over time.

Collecting premiums annually takes less administration time and reduces dropout rates. Many insured do not spontaneously pay their quarterly premium, and UHC staff has been forced to spend time improving collection efforts. Premiums are easiest to collect if a plan can piggyback on other financial systems, for example, adding the premium to school tuition or deducting it from the proceeds of crop sales or daily milk deliveries. Depositing premiums directly and immediately with providers reduces the opportunities for theft and fraud. While 10 percent of premiums go to UHC, it does not provide sufficient administrative revenues, or reserves.

The very poor are not likely to enroll in plans due to an inability to pay premiums. Subsidized premiums would be required to reach these groups. Currently, plans focus on the working poor.

[8] Three nets are provided per family, selling for 8,000 Shs ($4.50), with health providers contributing to their costs. Over 1,600 nets were sold as of May 1, 2003.

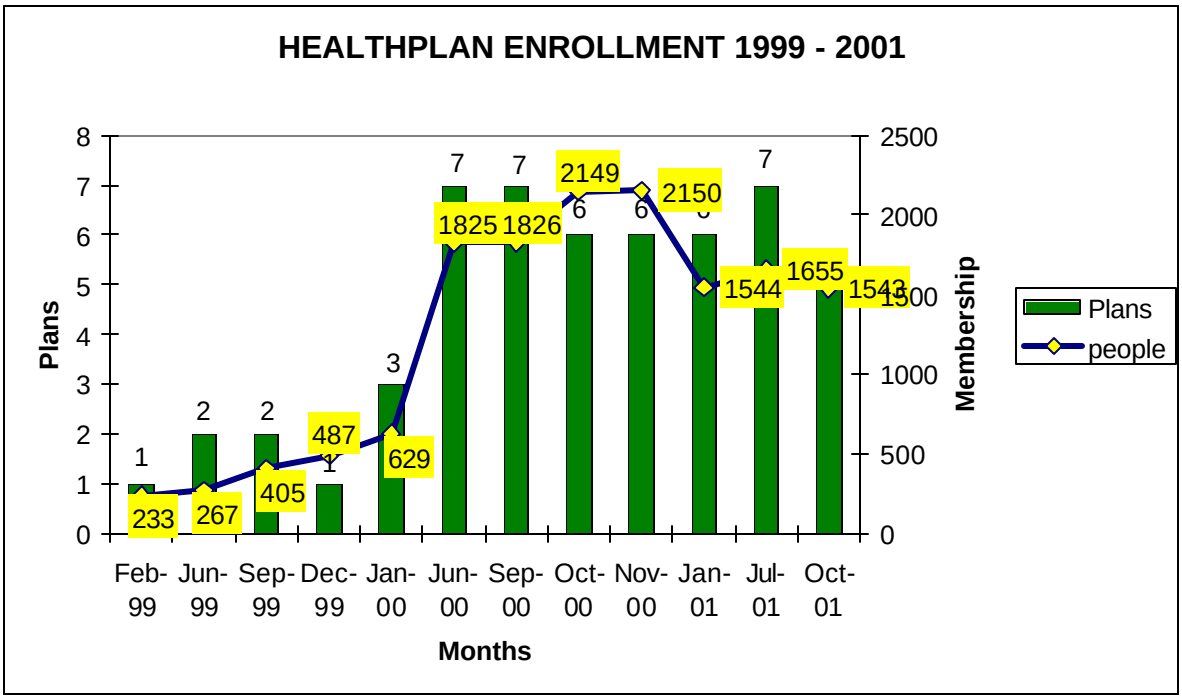
Despite a high birth rate in Uganda of 6.7, none of the UHC-supported plans elected to offer family planning as part of their coverage because these services are already heavily subsidized by the government and widely available. UHC also found that it was uneconomical to provide emergency transportation services for members.

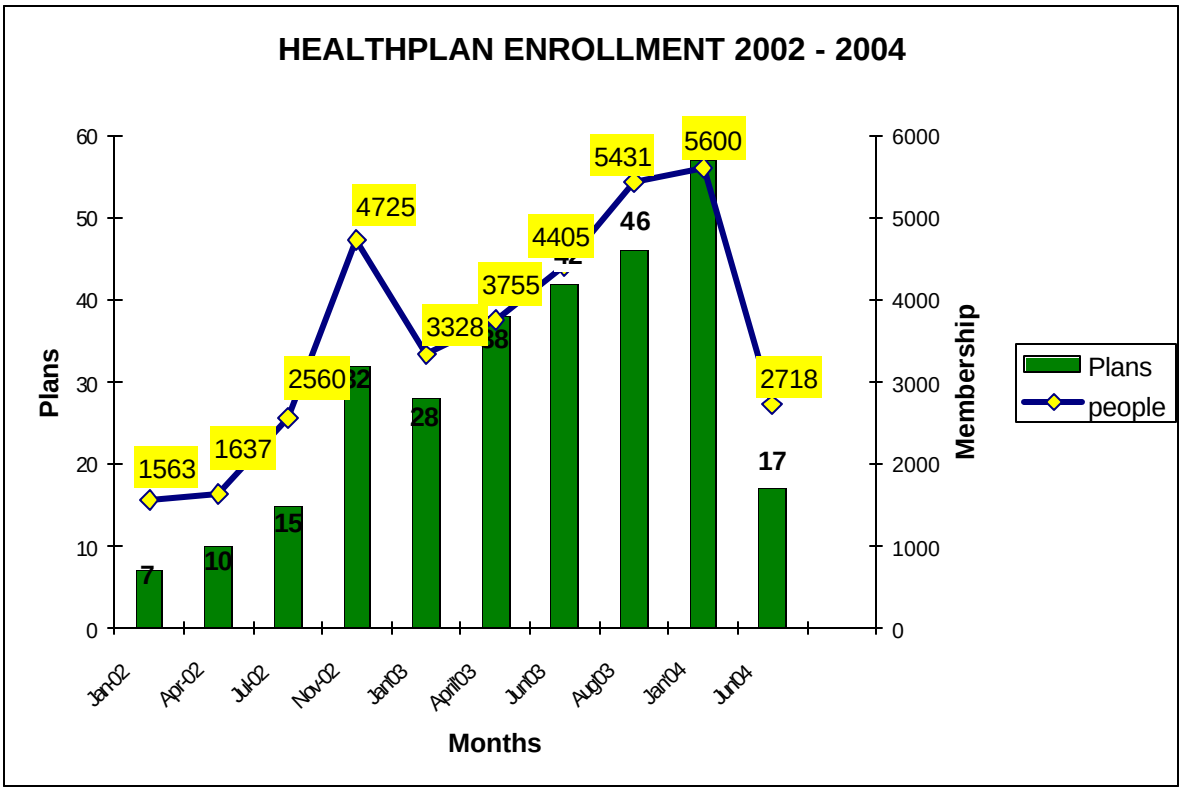
A study concluded in February 2003 that nonmembers utilize services more frequently than members of the health plans, members pay an average of 20 percent less on health care than non-members, and participating hospitals/providers indicated that UHC plans and reduced hospital losses resulted in more prompt payments of medical bills and increased access to health care by enrollees.

Due to low incomes in Uganda, affordable premiums currently do not cover the cost of photo ID cards, chronic care and comprehensive health services, premium collection, marketing staff and technical assistance. This presents a major challenge for sustainability and may require cost subsidization of lower-income by higher-income groups, and lower transactional and administrative costs through a larger pool of health plan members. Achieving scale remains an elusive goal.

VII. Scale and Sustainability

The first UHC health plan took effect in February 1999 and grew to three plans by January 2000. By June 2000, UHC had seven plans. From 2002 to 2003, plans grew to about 55 with about 5,600 members. Plans and membership fluctuate because of UHC staff cutbacks and the school calendar year. There is usually a decrease between January and March of any given year because schools are not in session. While some plans grow rapidly by about 100 a month, others decline because of dropouts and late payments. For example, if only one school is late with their premiums, it can represent a drop of 500 members.


HEALTHPLAN ENROLLMENT 1999 - 2001
Plans
Membership
Months
Feb-99
Jun-99
Sep-99
Dec-99
Jan-00
Jun-00
Sep-00
Oct-00
Nov-00
Jan-01
Jul-01
Oct-01
233
267
405
487
629
1825
1826
2149
2150
1544
1655
1543
Plans
people


HEALTHPLAN ENROLLMENT 2002 - 2004
Plans
Membership
Months
Jan-02
Apr-02
Jul-02
Nov-02
Jan03
April03
Jun03
Aug03
Jan04
Jun04
1563
1637
2560
4725
3328
3755
4405
5431
5600
2718
Plans
people

The key strategy for UHC growth has been to sign up and market plans to existing groups. Currently, UHC's largest growth is being achieved by promoting plans to primary and secondary boarding schools for students and teachers.[9] Plans are also promoted through hospitals and clinics by linking nearby groups with health care providers.[10]

Generally, larger and older plans absorb start-up costs of smaller and new plans since new enrollees tend to use health services more frequently when they gain coverage. UHC and Health Partners carried out a survey and determined that the current premiums were set at affordable rates and could not be increased to cover the subsidization of UHC staff and administrative costs.

In January 2004, HealthPartners had to absorb a reduction in grant funding and as a result scaled back plans, retaining those that were 100 percent or near self-sufficient. In June 2004, further reductions in donor funding required UHC to reduce staff from 12 to 4. These staff cuts resulted in a greater geographic focus on the Bushenyi District and an inability to promote and serve existing plans. In addition, one of the health providers eliminated paying the premiums for low-income groups with the plan, resulting in their termination. As of June 2004, there were 17 plans and benefit coverage for 2,718 members.

Of the seven major health providers in the UHC system, five are considered at 100 percent cost recovery, and two are between 70 percent and 80 percent recovery.[11] The major finding is that staff are required to perform premium collections and support plans because otherwise they appear to be unsustainable. Scaling up of plans resulted in high staff costs and did not provide efficiencies within the pre-paid health system.

Currently, health plans cover the cost of care but do not fully pay for the administration/salaries of UHC staff, which are subsidized at about $3,000 per month. UHC's strategy is to train health care providers, volunteer leaders and member coops in carrying out these administrative and operational services. UHC also has improved tracking of costs and subsidies.

[9] They include St. Mary's Vocational School, Kihyungye Primary School, Kyamuhunga Day and Boarding Primary School, Nyakashaka Primary School, Kashenyi Boarding Primary School, Nyabubare Secondary School and Kyanyakatura Day and Boarding School.

[10] In northern Uganda, they include St. Mary's Hospital Lacor and Maracha Hospital; in East / Central Uganda: Mbale People's Clinic and Maternity Home – Vienna, Well spring Health Centre, Community Health Centre –Mbale, KADIC Hospital, Victoria Medical Centre, Savannah Sunrise Clinic (SAS), Mukono Health Centre, Kansanga Health Centre, Marie Stopes Clinic and Joint Clinical Research; and in western Uganda, they include Comboni-Kyamuhunga Hospital, Ishaka Adventist Hospital, Bushenyi Medical Centre (BMC), Buhweju Satellite Clinic, Rugarama Health Centre, Kigonzi Clinic Kabale and Mayanja Memorial Hospital – Mbarara.

[11] See Annex A for details.

About 10 percent of premiums are provided to UHC and the remainder to the health provider.[12] Increasing premiums to fully cover administrative costs adversely affects the affordability of the plans. The premium structure was developed through earlier UHC studies and from its operational experience. Currently, 15,000 USh. (about $2 per month per family) in premiums cover the cost of care for the health plan coverage. A higher premium of 18,000 Ush, which is charged for some plans to higher-income groups, will cover most of the UHC administrative costs. An analysis of premiums and co-payments compared to utilization costs by health plans indicates that older and larger plans tend to subsidize smaller and newer plans.

There are two interrelated concepts in health insurance to achieve scale and sustainability. The larger the pool of healthy members, the more able plans are to cover the costs of those needing the services. Thus, larger health plans are likely to have more efficient per-client costs. Cost recovery also requires sufficient premiums and co-payments to cover services and costs of the health plan system.

In earlier project years, USAID was providing about $147,000 per year[13] to cover UHC administration and operational costs. Premium income will need to increase from 2 percent to 15 percent, depending on the number of members. The total premiums required to replace the USAID subsidy to UHC could be from just under $1 million to as much as $7.4 million.[14]

Premium % Increase	Premiums	Members
2.0%	$7,380,200	156,892
2.5%	$5,904,160	125,514
5.0%	$2,952,080	62,757
7.5%	$1,968,053	41,838
10.0%	$1,476,040	31,378
12.5%	$1,180,832	25,103
15.0%	$984,027	20,919

This increase in premiums and members does not take into consideration that to achieve scale will entail increased marketing costs. It is assumed that with a larger pool of insured and the aging of plans so that utilization decreases, UHC sustainability is possible. These financial resources must not only cover UHC costs but should provide for some reserves.

[12] The general standard in the insurance industry is about 30 percent of premiums, to cover promotion, marketing, claims and other operations.

[13] USAID plans to provide about $130,000 annually to HealthPartners and its UHC over the next four years.

[14] On average, the GDP per capita in Uganda is $1,400. Assuming that the average percentage expenditure on health is about 4.8 percent of total income, the average health costs would be $67.40. If we assume that 70 percent ($47) of that would be spent on the premiums, a participation rate between roughly 21,000 and 157,000 people is required to generate sufficient revenues for sustainability.

In considering UHC sustainability, it needs to be balanced with the understanding that public health is a public good. Governments and international donors have a responsibility to extend the safety net to those segments of the population that cannot afford health care. Members of groups participating in UHC programs that provide surplus revenues compared to costs of services also benefit from the good health in their communities.

UHC has pioneered in pre-paid health plans in Uganda and developed a strong methodology to deal with the usual risks associated with insurance programs. UHC has set premiums and co-payments to be affordable, but these revenues are insufficient to achieve UHC sustainability.

VIII. Conclusions

In 1997 and 1998, UHC studied the Ugandan health environment, hired staff, trained them in forging partnerships and laid the groundwork for health plans. In 1999, staff then began to mobilize and promote pre-paid health plans and iron out the mechanism of cooperative health plans. Studies and interviews with members found that their greatest concerns were that if they didn't fall sick, they would not need the plan. Also, health care providers complained about high treatment costs.

As plans began taking root, UHC introduced preventive medicine, partnered with another health donor to subsidize insecticide-treated mosquito nets to reduce incidence of malaria, promoted safety and hygiene training, and encouraged the provision of clean water with cisterns and improved sanitation with latrines. Members were taught how to build rainwater collection tanks. These initiatives improved community health, resulted in better cost recovery, and increased satisfaction levels by members with their plans.

At this point, UHC changed its focus to sustainability and improved marketing to increase membership to cover costs. Training was held for UHC staff, and incentives were put in place. Marketing efforts gained momentum, and preventive initiatives made the plans more appealing to new members. UHC researched and began to develop a strategy to introduce plans at new locations. As plan membership grew, new staff was added to handle marketing and provide preventive services (e.g., mosquito nets, clean water collection). UHC extended plans beyond the initial sites in the Bushenyi District to include health care providers in Kampala, Mbale, Kabale and Arua.

An important lesson learned from this outreach effort was that hiring and training local staff from rural areas lowered salary requirements and generated greater results. Local UHC staff were better attuned to their communities and better able to mobilize new plans.

Health providers needed continuing health plan education because of frequent staff turnover. This lack of understanding by provider staff resulted in discrimination against members through longer waiting times and sometimes the provision of fewer drugs than to non-members. Also, UHC staff needed to be present to answer questions and to

continue to mobilize larger and more sustainable member groups. UHC began to train volunteer leaders to improve services to members and help collect premiums, but volunteers were unable to substitute for a UHC staff presence.

As a result, UHC did not move closer to sustainability. Studies showed that members in rural areas could not afford more than 15,000 USh. per year per family of four. Higher rates led to high member dropout and slow growth of new membership. Additional services were not added to plans because premiums could not be raised to cover these services.[15]

Reasons to increase premiums were considered in order to improve provider services and the increasing cost of care because of inflation. The logic for not increasing premiums included the following: some members did not use the health care; not all treatments were covered; and some members felt they were discriminated against and received less care than non-plan members. Some respondents felt the care was not worth more, while others were afraid it would scare away potential members.

In December 2003, Land O'Lakes' funding to HealthPartners was cut, resulting in a reduction in UHC funding by one-third. Instead of UHC now growing plans, its focus shifted to improving plan efficiency. This was envisioned as a temporary move until additional funding was available. UHC staff worked with members and leaders of plans so that they would better understand recovery principles and how to prevent abuses in the use of services. HealthPartners prepared a proposal extension to continue health plan growth.

In preparation for a new sub-grant from Land O'Lakes, HealthPartners was asked to continue to work with UHC on sustainability and to add an initiative to address HIV/AIDS. This meant that plan premiums would need to cover the cost of care and administration. Funding for the new proposal was cut to $130,000 per year, which includes $58,400 for UHC staff and $21,000 for UHC administrative costs such as rent and travel (vehicle rental and gas, etc.). This budget leaves no room for training, mobilization, travel, consultants, studies, etc. Also, sustainability through scale is no longer possible.

In June 2004, UHC was forced to drastically reduce staff and health plan management, and to consolidate existing plans that were mostly self-sufficient. Plans were shut down in all outlying locations except Kampala and Bushenyi Districts. These were the oldest and most established plans with database tracking systems in place. These plans also had lower administrative staff salaries. UHC offered to try to be a resource for the plans that were shutdown if they wanted to continue with their own administrative staff and local resources.

[15] In a survey when members were asked whether or not premiums should be raised, 70 percent of respondents replied that they should not. The most commonly listed reason (43 percent) was that members do not have enough income for higher premiums.

Kabale decided to continue plans by using volunteer leaders to educate the community. UHC staff continues to help these plans by offering suggestions and training on issues when they arise. In a recent assessment (September 13, 2004), a plan leader commented, "Success will depend on reduced premiums and government to subsidize." A leader of another plan said, "Willing to continue but need assistance to our members."

FOCCAS (Freedom From Hunger) repeatedly entreated HealthPartners to train and pay for continued work in Mbale. The plan they set forth was unrealistic and far too expensive for the reality of the situation. When UHC discontinued staff involvement in this location, FOCCAS offered to hire UHC staff and is seeking funding. Comments from the recent assessment in Mbale suggest that the plan has not continued, but past members are still very interested in finding some way to have prepaid health plans.

Since June 2004, UHC has two mobilizers in Bushenyi District, one director in Kampala and one administration/accounting staff in Kampala. All plans are doing well. An assessment has been carried out, and the report is now being prepared. A new tracking device to help the mobilizers improve their goal setting and recordkeeping has been implemented. The assessment recommends the turning over of some administrative duties to co-op leaders and members and to improve health plan delivery to reduce the dependency on UHC staff. The goal is to have a sustainable health approach in place by June 2005 with additional tools to keep administrative costs down while growing the plans.

At this point, UHC may be able to take this improved package to scale. However, this will require a great deal more funding than $130,000 per year. In out-years, HealthPartners proposed working with UHC on an HIV/AIDS initiative that could be added to the pre-paid system with additional financial support from the Ministry of Health or other donors and programs that address this critical health crisis. Carrying out HIV/AIDS programs was seen as a means to increase UHC staff and its capacity to achieve scale.

Finally, the current proposed extension of the program with USAID funds should focus on achieving scale. The program is likely to require increased premiums and co-payments to cover UHC expenses and more enrollment of higher-income groups that can help cross-subsidize smaller plans and lower-income groups. An actuarial analysis is needed to determine various scenarios and a realistic plan for achieving scale and sustainability against which UHC can track progress with their current computer-based financial management tool.

To achieve scale and sustainability, it is likely to require substantially more donor resources, especially for marketing, than is currently provided to the UHC in the USAID grant. Annexes below on the number of cooperatives and businesses indicate that with sufficient resources, there are a large number of organizations that could be covered by the UHC system. To achieve scale will require a major marketing effort with donor subsidies as well as making sure that premiums are adjusted to cover administrative costs,

or other ways to service the plans can be found that allow for a large pool of beneficiaries and plans to have full cost recovery over time.

Annex A: Status of Current Health Plans (September 2004)

PROVIDER	PLAN BACKGROUND	INVESTMENTS	TRANSITION PLAN
ISHAKA SEVENTH DAY ADVENTIST HOSPITAL (BUSHENYI DISTRICT)	Five dairy/agricultural cooperative plans with over 400 members, and provider has non-UHC plans as well (600 members). Provider has been active with UHC since 1998. Cost recovery 80% Has not received subsidies in 3-4 years and plan owes hospital 10 million shillings.	Initial marketing and setting up of plan, now support about 50% of marketing Support preventive health initiatives Initial research documenting willingness to pay for health insurance. Past support under In-Net Uganda Health Information System (UHIS) site Internet and telephone link for UHIS UHC provided reinsurance for first year of operation.	Uganda Health Cooperative to assist Ishaka in raising health plan premiums and basic support for retaining current members during the time of premium raising. Investigate linking HIV/AIDS initiatives with health plan. Continue with support to UHC office based in Bushenyi District.
BUSHENYI MEDICAL CENTER (BUSHENYI DISTRICT)	Five dairy/agricultural and drama groups with over 500 members at two different sites, Bushenyi and Buhweju satellite (BMC with 10,000 non-UHC members mainly schools). Never a large recipient of subsidies from DfID funds. Provider has been active with UHC since 1999. Provider for Mother-Child Rescue Project sponsored by DfiD. Cost Recovery 100+%	UHC marketing about 10%-20% of plans Active site of UHIS Internet, UHIS telephone link and grounding of building Assisted in building Buhweju clinic and provided radio call system Provided rain water harvest tanks Buweju site of PBS "All Things Considered" special Past support under In-Net and Mother-Child Rescue Project. Provided contract support for all BMC insurance clients.	Provide basic UHIS support. Investigate linking HIV/AIDS initiatives with health plan. Plans are profitable and UHC to stop marketing for BMC plans.

PROVIDER	PLAN BACKGROUND	INVESTMENTS	TRANSITION PLAN
COMBONI CATHOLIC HOSPITAL (BUSHENYI DISTRICT)	8 groups including tea factory employees, students, traders and dairy groups with nearly 2,000 clients. Provider has been active with UHC since 2002. Cost recovery 70%-80%.	UHC provided 50% reinsurance for initial six months of plan. Contributes to 50% of health plan administrators cost. Provides general marketing and administrative support. Contributed to construction of health plan office. Gave support under In-Net Project.	UHC to continue providing marketing support for health plan retention. Install UHIS from Gulu and provide training so that Comboni can operate system. Investigate linking HIV/AIDS initiatives with health plan.
RUGARAMA HEALTH CENTRE (KABALE DISTRICT)	One large dairy cooperative with nearly 200 members. Provider has been active with UHC since 2003. Cost recovery consistently above 100%.	UHC provides majority of marketing and plan member retention support. UHC set up plan administration.	Plan needs to hire a dedicated staff member for marketing and administering health plan. UHC to withdraw marketing or administrative support.
MBALE VIENNA CLINIC (MBALE DISTRICT)	One school and one dairy cooperative with over 220 members. Provider has been active since late 2003. Cost recovery rates near 100%	UHC set up plan administration and provides marketing support	Very young plans; marketing and administrative support had to be withdrawn.
SAS CLINIC (KAMPALA)	Two groups, Uganda Microfinance Union and New Vision have some 100 employees enrolled with provider Provider has been active with UHC since 2001. Cost recovery consistently above 100%.	UHC provided general marketing support and advanced chronic disease marketing materials in exchange for a fee.	UHC to continue to provide general marketing support for a raised fee. UHC (based on a fee basis) is assisting two other Kampala-based providers in implementing health insurance plans and UHC support will continue.

PROVIDER	PLAN BACKGROUND	INVESTMENTS	TRANSITION PLAN
WELLSPRINGS HEALTH CENTRE (WAKISO DISTRICT)	One women's group with 40 members. Provider has been active with UHC since 2003. Group has been active with UHC since 2000. Cost recovery 100+%.	UHC provides marketing and set up plan administration.	Group needs to be given greater responsibility in terms of collecting premiums and general motivation. UHC to withdraw marketing and administration
LACOR HOSPITAL (GULU DISTRICT)	Site of Mothers Uplifting Child Health (MUCH) Project since 2000. Over 2200 clients and 34 groups enrolled via UHC with the aim of testing an intentionally subsidized health insurance plan. Approximately half of the clients have their premiums subsidized because they are women or children who are impoverished. Three-tiered premium structure depending on socio-economic status with subsidy paid by CMS.	UHC provides the vast majority of marketing and administrative support to plans out of dedicated MUCH office at Lacor Hospital. Three UHC employees are based at MUCH Project. UHC installed fully operational UHIS system. Gave support under In-Net Project. CMS and UHC provide subsidies and reinsurance of plans. UHC and CMS provided extensive research on plans.	Most UHC plans phased out. Lacor to pick up subsidy of the poorest groups. Without subsidies, the vast number of plans are at risk of not surviving.
UGANDA COMMUNITY-BASED HEALTH FINANCING ASSOCIATION (UCBHFA)	Umbrella group that represents the interests of over 10 different health plans. Active since 1999 Received support from DfID in the past now receives it from MOH directly and pays plans token amount for data collection.	Both CMS and Uganda Health Cooperative sit on management committee. Association began with seed funding from UHC.	UCBHFA has secured some minimal funding for operations next year from MOH, but not enough for decent marketing support for schemes. UCBHFA needs accounting and institutional strengthening. Elections for UCBHFA leadership are due soon.

Annex B: Project Start-Up

HealthPartners carried out an initial needs assessment, prepared a five-year work plan and conducted an initial survey on the status of local Ugandan dairy cooperatives with which the project would work. Information gathered included the number of members, types of services provided, financial earnings, group needs, preference in service delivery, the group's perception on quality of care and their source of satisfaction in health care, the perceptions of health insurance, existing leadership structures, the source of the group's social and or economic bonds, and other factors that would likely influence their decision making. This helped to determine the knowledge level of existing co-ops and helped tailor the information provided to them based on their level of understanding.

Also on this exploratory trip, meetings were scheduled with health care leaders in the private and nonprofit sectors. Alliances were formed early with the Uganda Ministry of Health, the USAID Mission, other internationally funded projects, local providers and most importantly, member groups. HealthPartners learned about existing conditions and potential partnerships to further the success of the projects in Uganda.

Dairy cooperatives were initially identified as potential members. Household incomes of dairy farmers had improved considerably with Land O'Lakes production and marketing projects. However, it was discovered that cows were receiving better health care than the people. Working with established groups was important because they tend to have a sense of how working together benefits everyone in the group. They provide a viable economy and are a preexisting aggregate of people working together for a common good. People already know each other, plan together, use the same resources, and share common problems, responsibilities and concerns. They feel a sense of belonging and unity sufficient to appreciate that any work done to the community will also be to their own individual benefit. They normally have management in place and conduct regular meetings, participate in risk sharing, which bonds them together, and they are familiar with the concept of group savings.

HealthPartners identified two dairy cooperatives to begin working with in milk-shed regions: Bushenyi/Ishaka (rural) and Kampala (urban). Dairy cooperatives already working with Land O'Lakes were located in these regions. Technical assistance, training and advisory services were delivered to host-country partners (related to health care).

Also on this initial trip, HealthPartners learned that the majority of the Uganda population does not have cash on hand. Since approximately 80 percent of the population is tied to agriculture (which is seasonal), it is common for people not to have cash during certain times of the year. This led to the development of collecting milk as a means for premium payments, instead of traditional cash payments. Groundwork was laid for the actuarial components necessary to determine the milk amount needed for the pre-payment scheme. HealthPartner's team of experts visited provider locations and met with physicians and administrators. They learned about the structure, services, successes and needs of the hospitals and clinics. The relationships established with these providers became the basis for the health plan test sites and later growth.

After 15 months of program development and planning, staff recruitment, and provider sensitization on the prepayment approach, the first scheme was launched in 1999 in Bushenyi District. The initial focus on two districts provided strong relationships for future support of the prepayment model and building linkages to access supplies and equipment. Each group selects their own leaders, caregivers, benefit structure and operative rules. Local health care cooperatives buy care as a group. Members of the co-op agree to pool money on a regular basis. The pooled money is used to pre-pay designated local health care providers who agree to provide a fairly comprehensive set of health care benefits. All care for plan members is delivered locally by those contracted providers. The model makes basic and essential levels of care both affordable and accessible to very-low-income people who otherwise would be either without access to care or unable to afford care.

The health plan concept has been well received by the rural population and participation is steadily growing.

HealthPartners utilized its staff for the following tasks:

- Recruit UHC staff
- Train UHC staff
- Create teamwork both for UHC staff and between our plans
- Learn Ugandan problems, situations and opportunities
- Problem solve
- Create communication channels and processes
- Design contracts
- Negotiate contracts
- Facilitate local co-op set ups
- Set up administrative systems
- Manage administrative system
- Assist with quality assurance programs

The lead role in coordinating Uganda activities for HealthPartners is filled by the Senior Vice-President Customer Services and Product Innovation. He has years of experience in several aspects of health care management, as well as expertise in setting up and negotiating provider contracts. As the team lead, he was initially responsible for hiring, training, management, provider contracting and budget planning for the Uganda project. The Senior Director Corporate Staff also played a role in the administration of UHC set-up. Like other HealthPartners volunteers, their time on the project was considered match contribution. In year three, a part-time coordinator was hired for the project. This was the only paid position on the U.S. side of the project.

Annex C: Key Terms and Concepts

Risk: Health insurance guarantees that funds will be available at the time of illness because members make regular contributions to the pool.

Benefit: The rights of the covered person or beneficiary to either cash or services after meeting the eligibility requirements of a covered plan.

Cooperatives: A group of individuals with no profit-making motive, the purpose of which is to shield their members and their families against the consequences of various social risks. The basic underlying principles include voluntary mutual aid, solidarity between members, nonprofit status, and self-promotion.

Co-payments (Co-pay): A flat dollar amount that is charged every time a service is provided. For example, members will be charged an office visit co-pay for most non-preventive visits to the doctor's office.

Diversify sources of financing for health care: Health Insurance channels private contributions from employers, individuals and the government.

Health insurance: A contract between a third party and a defined population to provide payment for a predetermined set of health services for a predetermined fee.

In-network: The group of health or dental care providers with whom a plan has contracted to provide services to members of the plan.

Open enrollment: The period during which participants in a benefit program have an opportunity to choose among health or dental plans being offered to them, or to change from one plan to another. The period when benefit-eligible employees and dependents may also obtain some optional insurance coverage without presenting evidence of insurability/good health.

Pre-existing conditions: A physical or mental condition of an individual that existed prior to the beginning of the individual's coverage under a benefit plan. Under certain circumstances, pre-existing conditions may be excluded from coverage.

Premiums: A set amount of money paid to the insurer in order to be a member of a plan. Plan membership fees if you will.

Provider: A doctor, therapist or other licensed medical or dental practitioner who provides health or dental services. A participating provider is one who contracts with a plan to provide services to members of the health or dental benefits plan.

Prepaid Health Plan: Protection that provides payment of benefits for covered sickness or injury. A prepaid health plan is a form of health insurance. People pay in advance based on the premium structure. They then access a specified range of both inpatient and ambulatory care whenever they need it. This continues until the next premium period when they renew. Payments are made from a pool of funds contributed by the population

and held by the third party, which can be government, a local body, an employer, an insurance company, or a provider.

Quotas: The minimum number of enrolled members from a specific group

Spreading Risk: The basic principal of insurance is to spread or share risk. Healthy people as well as sick people have to enroll in a health plan in order for insurance to work. If a health insurer only enrolls people with AIDS, for example, then the premium has to be the full costs of AIDS treatment plus a charge for administration. In that case AIDS patients would be better off just paying caregiver bills directly. If an insurance company only enrolls people with AIDS, but charges a lower premium than the cost of AIDS care, a premium based on the average cost of care for all non-AIDS patients, then the actuarial cost of claims will far exceed the total premium cash flow and the insurance company will go broke. Therefore, the only way for an insurer to survive is to cover both healthy and sick people whose total cost of care is less than the total premium.

To be solvent (debt-free), the total cost of *claims* must be lower than the total amount of revenue. The prepayment plan must be affordable and reach out to the broadest population while still adequately paying the health care providers whose involvement is absolutely necessary for the plan to succeed.

Annex D: Health Status of Uganda

Twenty-eight percent of all Ugandans report being sick in the past 30 days (29% for those in rural areas and 35% in the eastern districts. This is essentially the same as in 1999/2000. Fifty-six percent of those that fell sick report that illness was due to malaria, 14% respiratory infections, and 8% intestinal infections/diarrhea. Medical attention was sought for 36% of those reporting being sick in private clinics, 17% in health centers or dispensaries, 13% in drug shops, 11% home treatments, 9% in government hospital out-patient (down from 18% in 1999/2000), 7% none, 2% were inpatient and 1% from traditional doctors. The average distance to health facilities in rural areas are: 13 km to a hospital, 4 km to a clinic/dispensary/health center and 2 km to a drug shop. Mosquito net utilization is about 10%.

About 86% of households are rural with an average size for these households of 5.3. Urban households are about 4.1 in size. About 76% of rural households have a male head (64% for urban households). Approximately 14% of a typical household includes other relatives.

Fifty-seven percent of rural households report having access to safe water (84% urban). Three percent of households have inside toilets, 47% outside-built, 35% none and 15% outside not built. Fifty-seven percent have radios, 3% TV and 3% mobile phones.

In the rural parts of the eastern districts, the monthly household expenditure is 113,300 USh., and 184,000 USh. in urban areas (139,300 USh. for all of Uganda). Five percent goes to health care, 6% education, 4% clothing, 17% rent/fuel/power and 52% for food/drink/tobacco. Literacy in the eastern districts is 74% for males and 47% for females aged 18 years and above and 72% for males, and 54% for females aged 10 years and above.

Sixty-two percent of rural households members report averaging 2 meals a day, 8% one meal and 30% more than 2 meals. Twenty-three percent of children 0-4 years of age went without any breakfast. Seventy-two percent of rural individuals felt generally safe (51%) or very safe (21%), while 9% felt very unsafe and 15% neither safe nor unsafe.

Annex E: List of Cooperatives in Uganda

No.	Name of Society	District	County
1	Imato Ineno Ngei G.C.S. Ltd	Apac	Kole
2	Igel Alwala G.C.S. Ltd	Apac	Kole
3	Alito East G.C.S Ltd	Apac	Kole
4	Acan Pwonyere G.C.S Ltd	Apac	Kole
5	Atote Ka Opoto Ipige G.C.S	Apac	Kole
6	Alira G.C.S. Ltd	Apac	Kwania
7	Gwokere Nabieso G.C.S. Ltd	Apac	Kwania
8	Awila	Apac	Maruzi
9	Anenober Co-op. Society	Apac	Maruzi
10	Pukica Kamudini G.C.S.	Apac	Oyam
11	Acaba Tobacco G.C.S	Apac	Oyam
12	Loro Tobacco G.C.S. Ltd	Apac	Oyam
13	Alut Kot G.C.S. Ltd	Apac	Oyam
14	Oming Cane G.C.S. Ltd	Apac	Oyam
15	Butuku Cattle Marketing	Bundibugyo	Ntoroko
16	Ijumo Turihamwe	Bushenyi	
17	Rukoma Farming G.C.S Ltd	Bushenyi	Bunyaruguru
18	Kyambura Farming G.C.S	Bushenyi	Bunyaruguru
19	Shuuku Savings & Credit	Bushenyi	Bunyaruguru
20	Kitabi G.C.S	Bushenyi	Igara
21	Bumbaire Abategaya G.C.S. Ltd	Bushenyi	Igara
22	Bushenyi Peoples S&C Co-op. Soc.	Bushenyi	Igara
23	Bushenyi Mugume G.C.S	Bushenyi	Igara
24	Rukarango G.C.S	Bushenyi	Igara
25	Kajunju Abahambani G.C.S. Ltd	Bushenyi	Igara
26	Kitagata Kweterana G.C.S. Ltd	Bushenyi	Igara
27	Rutooma Kwerinda G.C.S Ltd	Bushenyi	Igara
28	Rushoroza Bekiza G.C.S Ltd	Bushenyi	Rihinda
29	Katenga Omunjoki G.C.S. Ltd	Bushenyi	Rihinda
30	Nyakahita Muhirwa G.C.S	Bushenyi	Rihinda
31	Mitooma S & C Ltd	Bushenyi	Rihinda
32	Bugongi S & C Ltd	Bushenyi	Sheema
33	Simuka Kyamurari G.C.S. Ltd	Bushenyi	Sheema
34	Mushanga Savings & Credit Society	Bushenyi	Sheema
35	Kyabandara G.C.S Ltd	Bushenyi	Sheema
36	Kyagaju Twitukye S.C. Ltd	Bushenyi	Sheema
37	Muhame S.C. Ltd	Bushenyi	Sheema
38	Kyeibanga G.C.S. Ltd	Bushenyi	Sheema
39	Kitagata S & C Ltd	Bushenyi	Sheema
40	Kabura Tweyambe G.C.S. Ltd	Bushenyi	Sheema
41	Kyempitsi Kishabya G.C.S. Ltd	Bushenyi	Sheema
42	Kashozi Mwetambire G.C.S	Bushenyi	Sheema
43	Buhubalo G.C.S	Busia	Samia Bugwe
44	Syanyonja G.C.S	Busia	Samia Bugwe
45	Lwande G.C.S	Busia	Samia Bugwe
46	Lumuli G.C.S Ltd	Busia	Samia Bugwe
47	Butema G.C.S. Ltd	Hoima	Bugahya
48	Kitana G.C.S	Hoima	Bugahya

No.	Name of Society	District	County
49	Kihambya G.C.S. Ltd	Hoima	Bugahya
50	Kidea S.C	Hoima	Buhaguzi
51	Namasere G.C.S Ltd	Iganga	Bukooli
52	Buwaga G.C.S. Ltd	Iganga	Busiki
53	Mpumiro G.C.S. Ltd	Iganga	Busiki
54	Nawansagwa G.C.S Ltd	Iganga	Busiki
55	Iganga Self Employed Women	Iganga	Kigulu
56	Lambala Environment & Technonology Women S & C Ltd	Iganga	Luuka
57	Lambala Agaliawamu	Iganga	Luuka
58	Nakabango G.C.S. Ltd	Jinja	Butembe
59	Budondo S.C. Ltd	Jinja	Kagoma
60	Kihanga Multipurpose Co-op. society	Kabale	
61	Bukinda Savings & Credit Society	Kabale	
62	Twekorere Savings & Credit Society	Kabale	Kabale
63	Kabale Municipality Emp. S & C. Society	Kabale	Kabale
64	Lyamujungu Financial Services Coop. Soc	Kabale	Ndorwa
65	Kacerere Farmers Co-op S & C Society	Kabale	Rubanda
66	Bululu Multipurpose S.C. Ltd	Kaberamaido	Kalaki
67	Kalaki Grs	Kaberamaido	Kalaki
68	Kampala Shoe Shinners S & C Society	Kampala	Kampala
69	Kidera G.C. S	Kamuli	Budiope
70	Butende Bakazi Tweweyo	Kamuli	Bugabula
71	Nabigwali Takira G.C.S Ltd	Kamuli	Bulamogi
72	Isingo G.C.S	Kamuli	Bulamogi
73	Kamuli Twisania S & C Coop. Soc	Kamuli	Kamuli TC
74	Nyamabuka Bukonjo	Kasese	Bukonjo
75	Bwera Katojo G.C.S	Kasese	Bukonjo
76	Karambi G.C.S	Kasese	Bukonjo
77	Nyakiyumbu G.C.S Ltd	Kasese	Bukonjo
78	Ibanda Buholho G.C.S	Kasese	Busongora
79	Ssagala Kweyamba G.C.S	Kasese	Busongora
80	Abasaija Ndimu Nkuuyu G.C.S	Kasese	Lake Katwe
81	Kayunga ACE	Kayunga	
82	Kangulumira G.C.S	Kayunga	Ntenjeru
83	Seeta Nyiize G.C.S. Ltd	Kayunga	Ntenjeru
84	Kayunga G.C.S. Ltd	Kayunga	Ntenjeru
85	Bwetyaba G.C.S Ltd	Kayunga	Ntenjeru
86	Kalibaimukya S & C Coop. Soc	Kibale	Bugangaizi
87	Kiboga Vanilla	Kiboga	Kiboga
88	Abakadyaka	Kitgum	
89	Akadot Farmers Coop. Soc.	Kumi	
90	Koena G.C.S	Kumi	Bukedea
91	Edoorot G.C.S	Kumi	Bukedia
92	Mukongoro Farmers C.S	Kumi	Kumi
93	Ario G.C.S	Kumi	Ngora
94	Ngora G.C.S	Kumi	Ngora
95	FAMCO Savings & Credit Soc,	Lira	Aloi
96	Anyangatir G.C.S. Ltd	Lira	Erute
97	Alunya Lwokwag G.C.S Ltd	Lira	Erute
98	Aweikoko G.C.S. Ltd	Lira	Erute

No.	Name of Society	District	County
99	Agwingiri G.C.S. Ltd	Lira	Kioga
100	Adong Kwan Mot G.C.S Ltd	Lira	Moroto
101	Ogo wei gwata G.C.S.	Lira	Moroto
102	Lango Union Employees S&C Cop.S.	Lira	Municipal
103	Abafuba Kalagala G.C.S. Ltd	Luwero	Bamunanika
104	Bukimu G.C.S Ltd	Luwero	Bamunanika
105	SAO Zirobwe S & C Ltd	Luwero	Bamunanika
106	Wobulenzi G.C.S Ltd	Luwero	Katikamu
107	Luwero Kezimbira G.C.S. Ltd	Luwero	Katikamu
108	Namiraali S & C Ltd	Luwero	Nakaseke
109	Kibinge Kweterekera S & C.S Ltd	Masaka	
110	Meeru G.C.S Ltd	Masaka	
111	Kisojo Multipurpose C.S Ltd	Masaka	Bukomansimbi
112	Kabwangu G.C.S. Ltd	Masaka	Bukoto
113	Luzinga GCS	Masaka	Bukoto
114	Wekolele Entegeka G.C.S. Ltd	Masaka	Bukoto
115	Lwengo S & C Ltd	Masaka	Bukoto
116	Kyotomanya S.C	Masindi	Bujenje
117	Bulima G.C.S Ltd	Masindi	Bujenje
118	Kisindi G.C.S	Masindi	Buruli
119	Kigumba G.C.S	Masindi	Kigumba
120	Bumulika G.C.S. Ltd	Mbale	Bubulo
121	Bayetana	Mbale	Bubulo
122	Butta G.C.S. Ltd	Mbale	Bubulo
123	Bukaweka G.C.S. Ltd	Mbale	Bubulo
124	Bumula G.C.S Ltd	Mbale	Bubulo
125	Buwasunguyi G.C.S Ltd	Mbale	Bubulo
126	Buwele G.C.S Ltd	Mbale	Bubulo
127	Bumagambo G.C.S Ltd	Mbale	Bubulo
128	Nambola G.C.S. Ltd	Mbale	Bubulo
129	Bubwaya S.C. Ltd	Mbale	Bubulo
130	Bukalisha S.C. Ltd	Mbale	Bufumbo
131	Limamushiri G.C.S. Ltd	Mbale	Bungokho
132	Bumasikye G.C.S. Ltd	Mbale	Bungokho
133	Mbale Women S.C. Ltd	Mbale	Bungokho
134	Bushiribo G.C.S Ltd	Mbale	Manjiya
135	Bumayoga G.C.S Ltd	Mbale	Manjiya
136	Kateshani S & C Ltd	Mbarara	Ibanda
137	Nyakatokye G.C.S. Ltd	Mbarara	Ibanda
138	Kihani Rwomuhoro G.C.S. Ltd	Mbarara	Ibanda
139	Rwamabaare G.C.S. Ltd	Mbarara	Ibanda
140	Masha Abarihamwe	Mbarara	Isingiro
141	Ebirungi Biruga S&C	Mbarara	Kashari
142	Bukiro Women G.C.S	Mbarara	Kashari
143	Ruhumba Agari hamwe G.C.S. Ltd	Mbarara	Kashari
144	East Ankole Diocese S.C Ltd	Mbarara	Kashari
145	Rubingo G.C.S. Ltd	Mbarara	Kashari
146	Kitura Savings & Credit Society	Mbarara	Nyabushozi
147	Kaaro G.C.S Ltd	Mbarara	Nyabushozi
148	Rwekimo Grs.	Mbarara	Nyabushozi
149	Bijubwe G.C.S Ltd	Mbarara	Nyabushozi

No.	Name of Society	District	County
150	Amamanzi G.C.S. Ltd	Mbarara	Rwampara
151	Kasheenyi S.C. Ltd	Mbarara	Rwampara
152	Abatahingurwa Kakigaani	Mbarara	Rwampara
153	Mutima Gumwe G.C.S. Ltd	Mubende	Rwampara
154	Mubende Teachers	Mukono	Mityana TC
155	Kyelima Akuyisa – Enkya G.C.S. Ltd	Mukono	Bbale
156	Kyelima Akuyisa – Enkya G.C.S. Ltd	Mukono	Bbale
157	Kukula kwa Buganda Co-op. Soc. Ltd	Mukono	Mukono
158	Ddundu Youth S & C Ltd	Mukono	Mukono
159	Mukono Teachers S & C Society	Mukono	Mukono
160	Mukono Savings & Credit Co-op Soc	Mukono	Mukono
161	Nabuka Diary C.S	Mukono	Mukono
162	Nakayaga G.C.S Ltd	Mukono	Mukono
163	Namayiba G.C.S Ltd	Mukono	Mukono
164	SAO Kisoga S & C Ltd	Mukono	Mukono
165	SAO Ngogwe S & C Ltd	Mukono	Mukono
166	Mukono Vanilla S C S Ltd	Mukono	Mukono
167	Muntuyera High School S & C. Society	Ntungamo	
168	Kajara Peoples	Ntungamo	
169	Butenga G.C.S	Ntungamo	Kajara
170	Abateganda G.G.S	Ntungamo	Ruhaama
171	Kyakashambara G.C.S.	Ntungamo	Ruhama
172	Katojo Twimukire G.C.S	Ntungamo	Ruhama
173	Acholi bur	Pader	Arru
174	Pogono G.C.S Ltd	Pallisa	Butebo
175	Morukokume G.C.S. Ltd	Pallisa	Pallisa
176	Kaukura G.C.S Ltd	Pallisa	Pallisa
177	Kameke G.C.S. Ltd	Pallisa	Pallisa
178	Nyarwanya S.C	Rukungiri	Pallisa
179	Hugu G.C.S. Ltd	Sironko	Budadiri
180	Mafutu G.C.S. Ltd	Sironko	Budadiri
181	Solokho G.C.S. Ltd	Sironko	Budadiri
182	Mukiyi Halasi G.C.S. Ltd	Sironko	Budadiri
183	Buwalasi G.C.S. Ltd	Sironko	Budadiri
184	Busamaga G.C.S. Ltd	Sironko	Budadiri
185	Mpogo GCS Ltd	Sironko	Budadiri
186	Muyobo Bula mbuli G.C.S.	Sironko	Budadiri
187	Bunanimi G.C.S. Ltd	Sironko	Budadiri
188	Elgon Co-operative Society	Sironko	Bulambuli
189	Nabongo G.C.S Ltd	Sironko	Bulambuli
190	Samazi G.C.S. Ltd	Sironko	Bulambuli
191	Okidetok Farmers C.S	Soroti	Kasilo
192	Awoja G.C.S Ltd	Soroti	Soroti
193	Kamuda Farmers C.S	Soroti	Soroti
194	Soroti Hospital Emp. S & C Ltd	Soroti	Soroti
195	Busabi G.C.S. Ltd	Tororo	Bunyole
196	Namage G.C.S Ltd	Tororo	Bunyole
197	Mugulu G.C.S. Ltd	Tororo	Bunyole
198	Butaleja G.C.S. Ltd	Tororo	Bunyole
199	Nabiganda G.C.S	Tororo	Bunyole
200	Kachonga G.C.s. Ltd	Tororo	Bunyole

No.	Name of Society	District	County
201	Apokor G.C.S	Tororo	Tororo
202	Merikit G.C.S	Tororo	Tororo
203	Morukonyangai G.C.S	Tororo	Tororo
204	Soni G.C.S	Tororo	West Budama
205	Gwaragwara G.C.S	Tororo	West Budama
206	Misasa G.C.S Ltd	Tororo	West Budama
207	Pawanga G.C.S	Tororo	West Budama
208	Nagongera Women G.C.S	Tororo	West Budama
209	Age Multipurpose GCS Ltd	Tororo	West Budama
210	Sop Sop G.C.S	Wakiso	Wakiso
211	Butale G.C.S	Wakiso	Wakiso
212	Simuka GCS	Wakiso	Wakiso
213	Bumali G.C.S	Wakiso	Wakiso
214	Luzinge G.C.S.	Wakiso	Wakiso
215	UCA Staff Cooperative Savings & Credit Society Ltd	Kampala	Kampala

Annex F: Number of Business Establishments by Employment and Region, 2001/2002

Region	Number of Businesses	Employment		
		Males	Females	Total
Kampala	56,489	111,368	76,150	187,518
Central	40,502	52,044	41,894	93,938
Eastern	29,839	45,170	20,660	65,830
Northern	9,763	15,313	7,893	23,206
Western	24,290	47,353	26,273	73,626
Total	**160,883**	**271,248**	**172,870**	**444,118**

Annex G: Number of Business Establishments by Sex and Employment Size Band, 2001/2002

ISIC Group	Number of Businesses	Employment (<5)			Number of Businesses	Employment (>=5)		
		Males	Females	Total		Males	Females	Total
Agriculture	90	180	61	241	359	9,556	4,986	14,542
Fishing	84	86	44	130	90	817	52	869
Mining & Quarrying	406	230	193	423	21	1,005	181	1,186
Manufacturing	9,543	15,078	3,695	18,773	2,425	55,510	12,848	68,358
Utilities	7	6	3	9	16	2,823	612	3,435
Construction	92	200	47	247	155	6,433	660	7,093
Wholesale & Retail Trade	104,461	78,708	68,660	147,368	3,025	23,514	7,393	30,907
Hotels, Bars & Restaurants	18,512	7,646	27,183	34,829	1,971	8,623	10,679	19,302
Transport & Communication	502	821	323	1,144	332	9,340	3,414	12,754
Finance & Insurance	294	409	307	716	245	4,333	3,051	7,384
Real Estate & Business Services	1,861	2,565	1,447	4,012	553	13,306	2,861	16,167
Education	251	348	258	606	228	5,525	3,472	8,997
Health & Social Work	2,601	2,112	3,393	5,505	672	5,368	6,523	11,891
Community, Social & Personal Services	11,609	11,915	7,907	19,822	477	4,791	2,617	7,408
Not Defined	1	0	0	0	0	0	0	0
Total	**150,314****	**120,304**	**113,521**	**233,825**	**10,569**	**150,944**	**59,349**	**210,293**

***Includes 176 businesses with missing employment data.*

Annex H: Ownership of Business Establishments by Ownership Type and Employment, 2001/2002

Ownership Type	Number of Businesses	Total Employment	Male	Female
Sole Proprietor	148,508	265,449	91,564	58,160
Partnership	6,075	25,223	9,868	4,756
Private Limited Company	4,322	107,976	5,789	1,381
Non-Govemment Organization (NGO)	595	7,708	277	139
Others**	1383	37,762	2220	785
Total	**160,883**	**444,118**	**109,718**	**65,221**

***Others include businesses whose ownership type is religious, joint government, statutory corporation, public limited company, cooperative, government and parastatal.*